

Mail completed application form to:
 Department of Labor & Industries
 Claims Section
 PO Box 44291
 Olympia WA 98504-4201



PRE-JOB ACCOMMODATION ASSISTANCE APPLICATION

One vendor per application form		Date of injury	Claim number
Injured worker's name		Accepted diagnosis	
Vocational counselor/job modification consultant			
Firm's name		Provider number	
Address		Phone number	
City	State	ZIP+4	

Proposed job title	
Proposed employer name (if available)	Phone number

DESCRIPTION OF PRE-JOB ACCOMMODATION

ITEMIZATION OF COSTS: Equipment _____ Tools _____ Other _____ Assembly, installation & delivery _____ Tax _____ Total \$ _____	REQUIRED DOCUMENTATION <input type="checkbox"/> Pre-job accommodation narrative report OR <input type="checkbox"/> Pre-job accommodation consultation report AND <input type="checkbox"/> Bids (if needed) AND <input type="checkbox"/> Ownership agreement AND <input type="checkbox"/> Attending Doctor's Statement of Medical Necessity	L&I provider number required for payment. If equipment vendor does not have a L&I provider number – Call: Provider Accounts (360) 902-5140 For payment, submit bill on pink "Statement for Retraining and Job Modification Services" form (F245-030-000). Attach copy of approved application
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Vendor name	Provider number
Address	
City	State ZIP+4 Phone number

Date	Vocational counselor or consultant signature	Employer signature (if contributed to costs)
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For Dept Use Only	<input type="checkbox"/> Approve	<input type="checkbox"/> Authorization code (0385R) entered on AUTH	<input type="checkbox"/> Authorization amount entered on CLOG	<input type="checkbox"/> Disapprove
Date	Signature authority			

Ownership Agreement for Tools and Equipment Purchased as a Pre-Job Accommodation

Worker _____ Claim #: _____

Return-to-work Goal _____ Date of Plan _____

Pre-Job Accommodations Required for Vocational Determination

- If the pre-job accommodation is purchased to satisfy the attending physician's requirements for a release to work (vocationally able to work), the worker upon his or her release to work will own the equipment detailed on the inventory.

Pre-Job Accommodation Required for Participation in a Retraining Plan

- The tools and equipment, as detailed on the attached inventory, are to be purchased as a pre-job accommodation for this worker's retraining plan. However, they remain the property of the Department of Labor and Industries until such time as this worker has successfully completed the retraining plan
- Permission to use these items is contingent on cooperative participation in the retraining plan and may be withdrawn at any time while the department remains the owner.
- The worker is fully responsible for the custody of the listed items, and he or she agrees to maintain these items and keep them secure from damage, loss or theft.
- Upon successful completion of the retraining plan, as determined by the department, the ownership of the listed tools and equipment will be transferred to the worker.

I understand the agreement as shown above and I am willing to comply with the terms.

Worker signature

Date

Witness signature

Date

Equipment Inventory

Item	Brand/Manufacturer	Model #

INSTRUCTIONS FOR COMPLETING THE PRE-JOB MODIFICATION ASSISTANCE APPLICATION FORM (F245-350-000)

NOTE: SUBMIT A SEPARATE APPLICATION FOR EACH VENDOR.

- 1) **DATE OF INJURY:** Record the date of injury.
- 2) **CLAIM NUMBER:** For the injured worker on whose behalf the application is being submitted.
- 3) **INJURED WORKER'S NAME:** Injured worker's full name.
- 4) **SOCIAL SECURITY NUMBER:** Record injured worker's social security number. It is helpful when the claim number is wrong and the worker's name is common.
- 5) **ACCEPTED DIAGNOSIS:** Record the accepted industrial condition(s).
- 6) **VOCATIONAL COUNSELOR/JOB MODIFICATION CONSULTANT:** Record the name of the individual submitting the application (must be vocational counselor, job modification consultant, or employer that has been trained in completing the applications.) May not be submitted by the worker.
 - a) **FIRM NAME:** Record the firm that the vocational counselor/job modification consultant represents.
 - b) **PROVIDER NO.:** Record the vocational counselor/job modification consultant's provider number.
 - c) **ADDRESS:** Record the vocational counselor/job modification consultant's address and phone number.
- 7) **PROPOSED JOB TITLE:** Record the actual or anticipated job title for which the application is being submitted.
- 8) **PROPOSED EMPLOYER NAME:** Record the employer's name and telephone number for the job title listed if it is available.
- 9) **DESCRIPTION OF PRE-JOB MODIFICATION:** Briefly list the equipment being requested and the reason for the request.
- 10) **ITEMIZATION OF COSTS:**
 - a) **EQUIPMENT:** Record the cost of equipment being requested.
 - b) **TOOLS:** Record the cost of any tools being requested.
 - c) **OTHER:** Record the cost of non-equipment, non-tool items, such as training time.
 - d) **ASSEMBLY:** Record the cost of assembly, installation and delivery.
 - e) **TOTAL:** Record total cost of modifications requested for this vendor.
 - f) **EMPLOYER'S PORTION:** Record the amount the employer will pay to the vendor.
 - g) **STATE FUND (SF) OR SELF-INSURED (SIE) PORTION:** Record the amount the SF or SIE is asked to pay.
- 11) **REQUIRED DOCUMENTATION**
 - a) **REPORT:** Specify which report type has been included with the application. If the report has been previously submitted, please indicate that it is "on file".
 - b) **BIDS:** Submit two bids for any item over \$1,500.00. If the item is only available from one vendor, please specify that it is a sole source item.
 - c) **OWNERSHIP AGREEMENT:** Must be submitted with the application. A standard ownership agreement for pre-job accommodations are available as page 2 of form F245-350-0000.
 - d) **ATTENDING DOCTOR'S STATEMENT OF MEDICAL NECESSITY:** Include verification from the attending physician that the accommodations are medically necessary due to the effects of the accepted industrial condition.
- 12) **VENDOR:** Enter the vendor's name, address, phone and provider number. Vendors must have a provider number in order to be reimbursed.